RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

General McLane School District - Edinboro

Your Workers' Compensation Insurance Carrier is: CM

Regent Insurance
300 Sterling Pkwy, Suite 100 Mechanicsburg, PA 17050

Phone: 1-717-590-8008

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR WORK INJURY.

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Name	Address	Phone	Area of Specialty
MedExpress (Multiple Locations)	5039 Peach Street Erie, PA 16509	814-866-1443	Urgent Care/Occupational Medicine
MedExpress (Multiple Locations)	18471 Smock Highway, Suite 107 Meadville, PA 16335	814-333-3627	Urgent Care/Occupational Medicine
St. Vincent Occupational Health (Multiple Locations)	2501 West 12th Street, Suite C Erie, PA 16505	814-452-7879	Occupational Medicine
Express Care at St. Vincent - West	4247 West Ridge Road Erie, PA 16506	814-835-2580	Urgent Care
EPN Urgent Care - Occupational Health - UPMC (Multiple Locations)	7200 Peach Street, Unit 16 Erie, PA 16509	814-860-3301	Occupational Medicine
EPN Urgent Care - Occupational Health - UPMC (Multiple Locations)	2861 West 26th Street, Suite 1 Erie, PA 16506	814-835-6695	Occupational Medicine
Orthopedic Associates of Meadville	11277 Vernon Place, Suite 200 Meadville, PA 16335	814-724-1252	Orthopedics
Orthopedic & Sports Medicine of Erie - UPMC	100 Peach Street, Suite 400 Erie, PA 16507	814-454-8287	Orthopedics
Greater Erie Niagara Surgery	145 West 23rd Street, Suite 101 Erie, PA 16502	814-454-1142	General Surgery
Allegheny Health Network Department of Neurosurgery (Multiple Locations)	2315 Myrtle Street, L90 Erie, PA 16502	814-452-7575	Neurosurgery
Contemporary Ophthalmology of Erie	2640 Zuck Road Erie, PA 16506	814-838-9555	Ophthalmology
James Spaulding, DC	106 Waterford Street Edinboro, PA 16412	814-734-3422	Chiropractic
Edinboro Family Chiropractic Inc.	12650 Edinboro Road, Suite 102 Edinboro, PA 16412	814-734-4541	Chiropractic

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
Corvel	For Prescriptions, Please Call	1-800-563-8438	Pharmacy
S1 Medical	Call Toll Free for Closest Location	1-888-945-5055	DME and Home Health

Panel Date: 4/6/2022

CM REGENT™ INSURANCE COMPANY
Workers' Compensation Division

Work-Related Incident Report

(To be conducted by the supervisor with the employee)

Note: This form is used to report employee and incident information to the insurance company. Please make sure all sections are filled out completely and accurately to ensure prompt filing with the insurance company.

Section One: Employee Information

Last 4 of Social Security #: _____ DOB: _____ Employee Name: _____

Home Address: _____ County: _____

Home Phone #: _____ Gender: M ☐ F☐ Employee's Job Title: _____

Department: _____ Primary Job Location: _____ Date of Hire: _____

Hours Worked Per Week: _____ Start Time: _____ Supervisor's Name: _____

Section Two: Incident Information

Date & Time of Incident: _____ Date Reported: _____ To Whom Reported: _____

Location of Incident (building, room, etc): _____ Type of Injury (cut, sprain, etc): _____

Injured Body Part: _____ Cause of Injury (machine, tool, liquid, etc): _____

Description of Incident (please describe in detail what happened):

Section Three: No Medical Treatment

☐ Returned to Work	☐ Returned to Work – Onsite 1st Aide Provided	☐ Sent Home

Section Four: Sent Out For Medical Treatment

Treatment: _____

Diagnosis: _____

Disposition:

☐ Return to work without limitations

☐ Return to work with limitations (describe):

_____

☐ May return to work on: _____

☐ Follow-up appointment with: _____ on _____

Medical Facility Name/Address: _____

Section Five: Signatures

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

General McLane School District
Internal Incident Investigation Report
(To be conducted by Supervisor)

Note: The information provided in this report will be reviewed at the monthly safety committee meeting and used to promote a safer working environment for all employees by identifying unsafe work practices or conditions. The contents of this report will not be used to criticize or penalize any employees injured on the job.

Employee Name _____ Date of Injury _____

1. Describe the basic cause(s) of the incident (what *specific factor(s)* caused the incident – what was the employee doing, how was the activity being carried out and what machinery, equipment, tools or objects were involved):

2. Would you describe this incident being the result of:

☐ work practice ☐ work environment ☐ both ☐ other _____

3. Was personal protection equipment or guards provided for this activity? ☐ yes ☐ no ☐ n/a

4. Was the personal protection equipment or guards being used at the time? ☐ yes ☐ no ☐ n/a

5. Should personal protection equipment or guards be provided for this activity? ☐ yes ☐ no

6. Are there safety rules that apply to this activity? ☐ yes ☐ no

7. How could this incident have been prevented?

8. Describe the resulting injuries.

9. Witnesses:

Name	Phone (day)	Phone (evening)

10. Explain in detail what actions could be taken to correct the unsafe act or condition.

11. Who is responsible for implementing the corrective action and when do you anticipate it will be accomplished?

Supervisor's signature _____ **Date** _____